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[MARCH, 1911.]

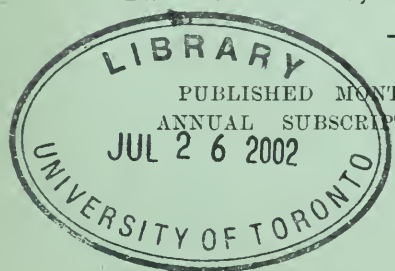
THE BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH JOURNAL OF DERMATOLOGY.

MARCH, 1911.

A CASE OF IMPETIGO HERPETIFORMIS IN A MAN.

By GRAHAM CHAMBERS, B.A., M.D.,

*Associate Professor of Clinical Medicine, University of Toronto;
Physician, Toronto General Hospital.*

T. C—, aged 40 years, farmer, was admitted under my care to the Toronto General Hospital on December 28th, 1909, for treatment of an eruption on his body and arms from which he had suffered for eighteen months.

The family history is good. Patient has always lived on a farm, and had good health until the present illness appeared. His habits had not been the best. He uses a good deal of tobacco, and for a number of years has taken both beer and spirits in excess, having got intoxicated about once a week.

About eighteen months ago the eruption began as a small patch on the left side of the chest, just below the armpit. The patient thought it was ringworm. The patch was made up of yellowish "blisters" set in a circular manner on a reddish base. During the next two or three days the patch increased in size and then new patches appeared in the neighbouring skin, but these never became as large as the one at the beginning of the eruption. In about a fortnight the eruption had extended to nearly every part of the body and also to the arms, but did not involve the scalp, face, or legs. The mucous membrane of the mouth was not attacked. The diseased patches dried up, forming crusts, which, falling, left reddish areas, but by the appearance of new "blisters" this attack lasted for three months. In the recurrences the locality of the eruption remained about the same.

Following this attack there was an interval of two months in which the patient was free from eruption. This was followed by another outbreak, which, however, was less severe, lasting between two and three weeks, and since that date the attacks appeared to be somewhat periodic, an outbreak of two or three weeks' duration alternating with a similar time in which the patient was free. The locality of the eruption remained about the same, *i. e.* the trunk and arms. Moreover, in the recurrences the disease usually appeared in the reddish areas which had been the seats of former attacks.

During an outbreak patient was feverish, felt ill, and suffered from headache and burning of the skin. In the intervals between the outbreaks he was in fairly good health. Since the illness began he has lost thirty-five pounds in weight.

Present condition.—The patient is considerably emaciated. He complains of a burning sensation in the seats of the eruption on the skin, and also of weakness, feverishness, loss of appetite, and general feeling of illness. The temperature varies from 98° to 101·5° F.

Cutaneous system.—On the trunk and arms there is an eruption which began a week ago. The legs, face, scalp, and mucous membrane of mouth are free. There is no eruption on the exposed parts of the body. The primary lesion is a pustule, varying in size from the head of a pin to a split-pea. There are no lesions containing clear fluid, and apparently the lesion is primarily a pustule. The eruption, which is roughly symmetrical in distribution, involves most of the skin of the thorax and upper abdomen, and also of the arms. There is only one patch on each forearm. The eruption consists of reddish surfaces, which apparently have been the seats of former outbreaks, on which the pustules are arranged, in some cases in clusters, in other circinately, and in others again irregularly. The eruption shows various stages of evolution and involution of the lesions, some just appearing, others drying into crusts, etc.

Microscopical examination of contents of lesions showed pus. Bacteriological examination with various media, in both aërobic and anaërobic states, failed to determine the presence of any organism.

Blood.—White blood - corpuscles, 9000; red blood - corpuscles, 3,600,000; hæmoglobin, 100 per cent. Differential count: Polynuclears, 64; small mononuclears, 28; large mononuclears, 5; eosinophiles, 2; mast-cell, 1.



TO ILLUSTRATE DR. GRAHAM CHAMBERS'S CASE OF IMPETIGO HERPETIFORMIS.



TO ILLUSTRATE DR. GRAHAM CHAMBERS'S CASE OF IMPETIGO HERPETIFORMIS.
MICROPATHOLOGY.

Digestive system and abdomen.—Tongue fairly clean ; teeth in good condition, with the exception of two decayed. At present appetite is poor. Liver and spleen normal in dulness. Stomach in normal condition.

Cardio-vascular system.—Pulse 96. No apparent arterio-sclerosis.

Respiratory and nervous systems.—Normal.

Genito-urinary systems.—The urine shows a trace of albumen and contains a few hyaline and slightly granular casts. A few red blood-cells are present. Indican slightly increased in quantity. The functional activities of the kidneys appear to be normal.

PROGRESS OF THE CASE.

For three days after the patient was admitted new lesions continued to appear. They always began as miliary pustules. At the same time many of the older pustules dried up into crusts. Temperature slightly elevated in the evenings.

January 2nd to 8th : Patient improving. Very little burning of the skin. Temperature normal.

January 12th : Pustules and crusts have all disappeared. Patient feels much better. Urine contains a trace of albumen and hyaline and granular casts, but no blood. Indican not increased.

January 28th : Patient feels ill. Complains of headache. Appetite poor. Fresh outbreak of the eruption, which is essentially the same as that of previous attack. Temperature somewhat elevated. Blood and urine the same as in former attack.

February 7th : The eruption has almost disappeared. The patient feels improved in health.

February 18th : Patient left the hospital. No pustules on body.

Three months later it was ascertained that the outbreaks had continued to appear, but were less severe.

MICRO-PATHOLOGY.

The upper drawing represents a section of an early stage of the formation of a pustule. In the mucous layer, which is thickened, there is an area of necrosis which extends outward almost to the stratum corneum. The necrotic patch shows large clear cells, exhibiting finely granular degeneration and slightly acidophilic reaction, surrounded by polymorphonuclear cells—the picture of a commencing intra-epidermic abscess. The nuclei of the epidermic cells

involved in the necrotic are indistinct and stain poorly. The corium shows perivascular infiltration with mononuclear and polymorphonuclear cells, but no marked congestion of the papillæ. In some places the infiltration extends to the under-surface of the epidermis, and lines of polymorphonuclear cells illustrate how these cells worked their way up to the area of necrosis in the epidermis.

In the lower drawing the magnification is somewhat less. This represents a section of a fully-developed pustule. The condition of the corium is very similar in both drawings. In the epidermis there is an abscess, intra-epidermic in situation, with the horny layer forming the roof and the remaining portion of the mucous layer the base. The papillæ under the abscess are flattened.

TWO UNUSUAL FORMS OF SYPHILITIC NAILS: WITH SOME GENERAL REMARKS UPON SYPHILIS OF THE NAIL.

By H. G. ADAMSON, M.D., AND J. E. R. McDONAGH, F.R.C.S.

THE chief object of this paper is to record two examples of syphilis of the nail of unusual type. Before describing these some attempt will be made to review our knowledge of the better-known forms of nail trouble which may occur as a result of syphilis. There are several kinds of syphilitic nail affection; but in proportion to the large number of cases of syphilis, all are comparatively uncommon, and some are distinctly rare.

It is probably because of the rather infrequent occurrence of syphilitic nail troubles that writers give somewhat different accounts of these affections—each observer has seen but few cases, and consequently he is inclined to lay stress upon those particular forms which have come under his notice. It is only by comparing the observations and views of different writers that it is possible to get a general idea of these affections; and for the following account, among other works which have been consulted are those of Delpeche, Cazenave, Hebra, Fournier, Baumler, Batut, Heller, Finger and Sabouraud.

Leaving aside chancre of the finger-nail, which may sometimes involve the nail-bed, the nail changes that may occur in the course of secondary and tertiary syphilis may be divided into two main groups: In the first group are those in which there is no obvious inflammatory affection of the skin immediately around the nail, or of

the nail-matrix, or the nail-bed—in other words, in which the changes seem to be confined to the nails themselves: in the second group are those in which the nail changes are undoubtedly a consequence of some inflammatory condition of the parts beneath or around the nail.

The first group are commonly known as Dry onychias—*Onychia sicca syphilitica*. The second as *paronychias* or *perionychias*.

I. ONYCHIA SICCA SYPHILITICA.

The various forms of dry onychia which have been described may be classified as follows:

(1) A brittle condition of the nails, so that the free ends tend to split and break when trimmed with scissors or knife, or as the result of slight injuries, and the nail border becomes notched or serrated. All the nails may be involved, but especially those of the hands. Fournier has described this condition as more common in women, and as not of rare occurrence, and he has given to it the name of *onyxis craquelé*. There is apparently no thickening nor opacity of the nail in these cases, but merely an unusual brittleness with a tendency to splitting and fissuring.

(2) A pitting of the dorsal surface of the nail, the pits being arranged more or less in a linear series from the root forwards. The pits begin as whitish points in the nail which can be dug out with the point of a knife, and which eventually leave roughened, blackened holes. These pitted nails have been carefully described by Batut.

(3) In other cases the whole nail may become dull, dry, thickened, brittle, fissured, and tending to crack and to split at its free margin. Fournier has likened such nails to the pith of rushes. Cazenave says that sometimes the nail becomes thickened, opaque, and wrinkled in two-thirds of its extent, and that there is generally a distinct line of demarcation between the diseased portion and the sound portion, which retains its polish and colour. In some cases, he says, the change in structure is general, and the nail is converted into a horny, dry, greyish, very brittle body. The appearance, described by Cazenave, of a nail, part normal and part diseased, is, of course, due to the fact that a part of the original nail still remains, with the diseased nail growing up behind it, or that a new nail is appearing

behind the diseased. A case which well illustrates this form of nail will be presently described. Probably this condition is only a more advanced state of the two preceding forms, onyxia craquelé and pitted nails.

(4) A few examples of a hard, wedged-like thickening of the free end of the nail have been described.

(5) Fournier, Batut, Sabouraud and other writers mention partial or complete separation of the nails during the course of syphilis without any other local symptoms, and in a painless or "silent" manner. Sometimes the new nail is of normal formation; sometimes it may be of the type of onychia sicca described in paragraph 3.

(6) Heller has recently published two cases of syphilitic nail of a type new to him, which are described by the title which he gives them of "*Striæ longitudinales medianæ unguium syphiliticæ*."

(7) Whitfield has noted that "a grooving of each nail may register the period of greatest disturbance of nutrition." Such transverse grooves—Beau's lines—are well known as a result of various general nutritive disturbances other than that produced by syphilis.

Most writers state that syphilitic dry onychias are of rare occurrence. Excluding his two recently published cases of median striation, Heller saw only three examples in eight to nine thousand cases of syphilis, whose nails were especially examined. He also quotes Rayer as remarking upon the rarity of the complaint. In 6047 cases of syphilis, observed from 1864–1874 in the Copenhagen Hospital, Bergh found only four cases of syphilis of the nail—including all kinds of syphilitic onychia. On the other hand, Fournier, as we have seen, says that "onyxia craquelé" is not of rare occurrence, and Cazenave (1843), writing of the dry opaque, brittle nail, says that this form, "which was well known to the ancients," is very common. Dr. Pringle, in a discussion which followed the exhibition of the case to be immediately described, said that he had seen several such examples, though less severe, and that he was surprised to hear that the condition was considered so rare.

Much difference of opinion is expressed as to whether these "dry onychias" are the result of local syphilitic manifestations in the nail-bed, or due to general nutritional disturbances. Kaposi says: "Whenever disease of the nails occurs in syphilis we look upon it as the direct consequence of disease of the matrix and of the bed of the nail, and

PLATE I.



FIG. 1.—Onychia sicca syphilitica.



FIG. 2.—The same case as Fig. 1, six months later.

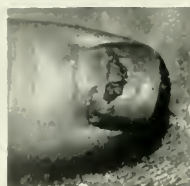
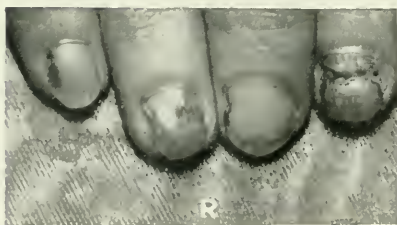


FIG. 3.—Papule formation on nail-bed (Mr. Shillitoe's case).

TO ILLUSTRATE DR. ADAMSON AND MR. J. E. R. McDONAGH'S PAPER ON TWO UNUSUAL FORMS OF SYPHILITIC NAILS.

only as an indirect result of the syphilitic dyscrasia." Heller also regards these onychias as the result of local lesions. Finger, on the other hand, speaks of the changes in the nails in syphilis from general nutritional disturbance, analogous to those occurring in the hair from like causes. This is a point which will be referred to again presently.

There is considerable variation as regards the period of the disease at which "dry onychias" may occur. They are reported as early as six to eight months after infection, and as late as the tenth year. Heller's cases were at two and a half years, six years, and ten years. Batut remarks that these lesions "may supervene either in the virulent phase of syphilis or much later, towards the twentieth month, as isolated phenomena indicating the persistence of the syphilitic virus in the absence of other manifestations."

The following two cases illustrate some of the features of *Onychia sicca* which have just been described.

A Case of Onychia Sicca Syphilitica.

This case, which was exhibited at a meeting of the Dermatological Section of the Royal Society of Medicine, and a note of which was published in the *British Journal of Dermatology*, February, 1910, vol. xxii, p. 52, is an example of a commonly described form of *Onychia sicca syphilitica*.

Briefly, the case was as follows: The patient was a man, aged 56 years, who had, when first seen, a squamous syphilide upon the scrotum, flat condylomata and shallow ulcerations on the tongue, and the condition of the nails seen in the photograph (Fig. 1). The proximal part of the nail was thickened, opaque, ridged and pitted, and friable. The distal part, from which it was sharply marked off, had its normal transparency and polish. Six months later the dystrophied nail had grown forwards and had entirely replaced the healthy nail, so that the whole nail was then roughened, pitted, opaque, and brittle (Fig. 2). The subsequent history is not known.

A Case of Onychia Sicca with Transverse Groovings and Longitudinal Striation.

The patient, W. F—, contracted syphilis in 1906. He was treated with pills on and off during four years and also had sixteen injections

of mercury (? in what form). When the patient first came under observation in January, 1911, he had a psoriasiform syphilide affecting both palms. All the nails on the hands, but not those on the feet, were affected in the following manner: They were more brittle than natural, and covered with fine longitudinal ridges. The central part of each nail was raised and convex, and with marked transverse grooving, some of the grooves being pigmented. On some of the nails the transverse grooving extended from top to bottom. In others the grooves, which had grown forwards from the lunula, were limited to the anterior part of the nail. The condition began two years after infection in the thumb of the right hand, and soon afterwards the other nails became affected.

II. PARONYCHIA OR PERIONYCHIA.

The second form of syphilitic nail in which the nail lesions are obviously secondary to local inflammatory disturbances includes two varieties:

(a) Papular or pustular lesions on the nail-bed (the "isolated papule" of Heller).

(b) Papulo-crusted or ulcerative lesions around the nail, and involving also the matrix and nail-bed—Perionychia, Paronychia desquamativa, Syphilis ulcerosa unguium, Paronychia pustulosa, etc.

(a) *Papule on the Nail-bed.*

Each of these varieties is said to be more common than Onychia sicca. Heller describes the first under the name of "the isolated papule of the nail-bed." He says it occurs at the time of the exanthem. A pea to bean-sized patch appears under the normally transparent nail. At first the patch is intensely red, later yellow, and without pustulation. The nail-plate gets thinner at this spot, and finally crumbles away, leaving a gap in the nail. He states that it is always limited to one finger. Finger says that the papule on the nail-bed often accompanies palmar or plantar psoriasiform syphilides, and that it may sometimes be half on the skin and half on the nail-bed. The following case, for permission to publish which we are indebted to the kindness of Mr. Shillitoe, is a striking example of the

sypilitic papule on the nail-bed. It differs, however, from Heller's type in that nearly all the finger-nails were involved.

Mr. Shillito's case.—Patient was a male, aged 23 years. The nail changes appeared, about four months after infection, as part of a general papular eruption, which involved the palms and soles. The lesions of the nails persisted after the general eruption had disappeared. They were the result of the formation of papules on the nail-bed, the nail-plate immediately over the papule becoming secondarily affected. At the time when the photographs (Fig. 3) were taken all the nails of the hands were affected; the little finger of the right hand (r) and the ring-finger of the left (l.) showed early papules beneath the lateral margin of the nail. The thumb of the right hand showed complete perforation of the nail-plate subsequent to the formation of a papule at the central part. There was some discharge of pus from the more advanced nail-bed lesions. A marked feature in this case, which can be observed in the photograph, was the deep pigmentation of the nails over the papules, a pigmentation to which attention has been especially called by Vörner, and which has been shown to be due to changes in the horny substance, due to exposure to the air and not to a deposit of true pigment.

The photograph (Fig. 4) is an example of another case of papule formation on the bed of the nail. In this case the nail has not been eaten away, but it has been separated from its bed at its anterior part by the formation of the papule there. Patient was a male, aged 37 years, and the nail trouble had commenced as part of a secondary generalised papular eruption six months after infection.

(b) *Paronychia* or *Perionychia*.

The other form of sypilitic nail associated with inflammatory disturbances is that known as *Perionychia*, *Paronychia desquamativa*, and *Syphilis ulcerosa unguium*. Several nails may be affected, but often only one is involved, and, commonly, that of the thumb, of the first finger, or of the great toe, probable because these are most exposed to injury, which acts as a determining cause. There is at first redness and swelling of the parts around the nail, with some pain, though generally less than is the case with acute septic paronychias. If the case is not under treatment the inflammation may extend beneath the nail to the matrix and nail-bed, and the skin around the nail

gives way, forming a discharging horse-shoe-shaped ulcer. The nail blackens and falls, exposing an unhealthy-looking ulcer. If the inflammation of the matrix has not been severe a normal nail may grow under treatment, but often the nail is afterwards deformed, or no new nail may be produced.

The photograph (Fig. 5) shows a syphilitic perionychia in the early stage, at which it was arrested by treatment. A striking example of *Syphilis ulcerosa unguium* is figured by Heller (p. 166, *Die Krankheiten der Nägel*) with horse-shoe-shaped ulceration around the nails.

TWO UNUSUAL CASES OF SYPHILIS OF THE NAIL.

Having completed this short survey of the better-known forms of syphilis of the nail, we now turn to the consideration of the two cases of unusual type which are referred to in the title of this article.

CASE 1.—J. L—, a man, aged 25 years, developed syphilis when twenty-one years of age. The chancre was followed by slight secondary manifestations, which disappeared under a six months' course of mercury given internally in the form of hyd. c. cret. Internal treatment was discontinued owing to the fact that the tongue became very sore. It was considered at that time to be due to a mercurial stomatitis, but as the tongue continued to get worse, the patient received, a year later, ten mercurial injections of grey oil, which had no influence in improving the glossitis. Consequently mercury was no longer prescribed, and from that time until the patient came under observation in the beginning of November, 1910, he had received no anti-syphilitic treatment. On examination, the tongue was smooth and shiny on the surface, there were no papillæ, and the whole of the upper surface of the tongue was covered with patches of leucoplakia, in between which were scarred fissures. On palpation the tongue was soft, except in a few places where the fissures were, indicating also some interstitial glossitis. There were no leucoplakic patches on the mucous membrane on the under surface of the tongue, nor elsewhere in the mouth. Except for a peculiar condition of the nails the patient showed no other evidence of syphilis. The patient was accustomed to smoke, but not excessively. There was no evidence of gastro-intestinal disturbance. Wassermann's reaction was positive.

PLATE II.



FIG. 4.—Separation of the anterior part of the nail as the result of a papulo-pustule of the nail-bed.

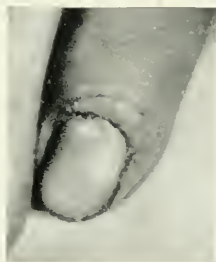


FIG. 5.—Paronychia syphilitica.



FIG. 6.—Syphilis of the nails. The nails are remarkably thin and soft, ridged longitudinally, and split at their free ends.

TO ILLUSTRATE DR. ADAMSON AND MR. J. E. R. McDONAGH'S PAPER ON TWO UNUSUAL FORMS OF SYPHILITIC NAILS.

Nails.—The nails of both hands were malformed, except that of the ring-finger on the right hand, which was normal. The nails on the feet were unaffected. The affected nails were short and irregular at their free ends, as if they had been bitten. The nail-plates were abnormally thin, so that they felt soft along their whole length. They were somewhat concave in the centre and irregular on the surface, due to parallel longitudinal ridges. There was no lunula, but in that position the nail was extremely soft. The skin over the root of the nail appeared raised and had the feel of a sac, which could be flattened out on pressure. This was no doubt due to the fact that the roots of the nails were soft and gave no support to the skin above them. Only when the nails first became bad was there any pain. The pain was situated at the bases of the nails, the parts around which were at that time inflamed. The onychia commenced about six months after the infection, and, according to the patient's history, one nail after the other, except the one mentioned above on the right hand, became sore and soft at its base, and within a short time the nail fell off, the nail taking its place having the characteristics as above described.

On November 11th the patient received .6 gm. of "606" intramuscularly; within a few days the pain in the tongue had vanished, so that the patient could eat or smoke in comfort. When next seen, on January 11th, 1911, the tongue had greatly improved; the surface was still shiny, and the leucoplakic patches had not disappeared, but the consistency was softer. The Wassermann reaction was negative. In the nails there was no appreciable change.

CASE 2.—H. H—, a man, aged 31 years, seen at the beginning of November, 1910, had a chancre on the lip two years ago, which was followed by the usual secondary symptoms. Treatment was commenced with forty inunctions, when the rash was diagnosed as being syphilitic; pills were then taken for eighteen months and followed by fifteen injections of grey oil. The patient now sought advice for a nasal discharge of three months' duration, caused by a perforation of the nasal septum, the edges of which were ulcerated and the ulcer spreading. There was much discharge, so that the patient's pillow was soiled every morning. There was a scar on the left side of the neck caused by *Lupus vulgaris*, which had been cured by "light treatment" five years previously. Except for the nasal trouble and the condition of

the nails, which will be presently described, there were no other manifestations of syphilis. Wassermann's reaction was positive.

Nails.—Every nail, both on the hands and feet, was shortened, soft to the touch, jagged at the free edges, ridged longitudinally, and concave in the centre. The nails were extremely thinned but retained their normal translucency, having much the consistency of a soft quill. The root of the nail was particularly soft and offered no resistance to pressure, the skin over it being, as it were, puffed out and wanting the support of the nail, a feature which can be seen very well in the photograph (Fig. 6). The patient had always had bad nails, as he had been in the habit of biting them. The nail condition started about six months after infection, with red, painful swelling at the base, affecting the fingers one after the other. The old nail soon became shed, and the new one taking its place had the appearance as above described, but never grew beyond a certain length. Although the base of the nail was soft and the skin over it raised, there was no pain at the time of examination. On November 15th patient received .6 grm. of "606" intra-muscularly. Within ten days the ulceration in the nose had healed and the discharge had ceased. When seen again on January 11th, 1911, the nasal condition had completely healed; the nails remained unaltered. Wassermann's reaction was negative.

REMARKS UPON THE TWO CASES JUST DESCRIBED.

These two cases of syphilitic nails have many features of interest. In the tendency to longitudinal ridging and fissuring and to breaking of the nails at their free margins they resemble the onyxis craquelé of Fournier, but they are peculiar in that the nails were so exceedingly thin and soft to the touch, while still retaining their normal texture and translucency. In each case the onychia began at about six months after the infection, and was still present in one case four years and in the other two years afterwards, in spite of mercurial treatment. In one case all the nails of both hands, except one nail, were involved; in the other every nail, both of the hands and of the feet. A notable feature is that, although in both cases, at the time they came under observation, the onychia was of the type described as Onychia sicca, yet in each there was a history of pain and inflamma-

tion at the root of the nails when the onychia first made its appearance, and this inflammation was followed by fall of the normal nails, which were replaced by the present deformed nails. Without denying that Onychia sicca may in some cases result from a general nutritive disturbance, it seems clear that in these two cases it was the consequence of a local inflammatory lesion of the roots of the nails, and it seems probable that the persistence of the lesions is due to a permanent damage to the matrix by the early inflammatory disturbance. It is noteworthy that the condition of the nails showed no improvement two months after injections of "606."

In contrast with the want of improvement in these two examples of Onychia sicca, it is worthy of note that in Mr. Shillitoe's case of recent papulo-ulcerative lesions of the nail-bed (Fig. 4) there was marked improvement after the injection of "606."

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ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

Dr. ADAMSON showed a case of *unilateral pigmentary nævus*. The patient was a young woman, aged 18 years, who was under the care of Dr. Woodwark for heart trouble. The pigmentation was in the form of split-pea-sized, deep brown macules, thickly sprinkled over

the side of the trunk from the level of the nipple to the crest of the ilium behind, and to the inguinal fold in front. The area occupied by the pigmentary macules was strictly limited by the middle line in front and behind. There were no fibrous nodules suggestive of Recklinghausen's disease. The macules, according to the patient's account, had been present only a few years, but there was another feature, namely, a supernumerary nipple on the right side, which suggested that the pigmentation was also a congenital defect. Although not, strictly speaking, linear in distribution, the case should be grouped, the exhibitor thought, with *nævi* of the type of unilateral linear *nævus*. It was now known that *nævi* of this type might consist of any one, or more than one, of the elements of the epidermis or its appendages—for example, it might be, as commonly, made up of horny cells; it might be entirely of sebaceous glands, or of sweat-glands; it might be, as in the present case, pigment only.

Dr. F. PARKES WEBER said the larger patches of cutaneous pigmentation looked exactly like those of Recklinghausen's disease, though the distribution of the pigmentation was unilateral.*

Dr. GRAHAM LITTLE thought this case the counterpart of the case shown by Dr. Parkes Weber, and figured in the *British Journal of Dermatology*, 1909, p. 51, but shown to the Dermatological Society of London in May, 1905. There was the same two-fold pigmentation in smaller and darker spots, and larger, less dark patches. The possibility of Dr. Weber's case being an early and incomplete Recklinghausen's disease was discussed when it was shown, and the chief difference in the two cases was the unilateral distribution of the present case. That pigmentation could precede the development of tumours in Recklinghausen's disease by many years was exemplified in a case shown by Dr. Little (*Brit. Journ. Derm.*, 1908, p. 413), in which the patient, a boy, aged 12 years, had had pigmented areas since birth, and had developed molluscous tumours only at the age of ten, the pigmentation having also increased in the interval.

Dr. ADAMSON also showed a case of *congenital xanthoma* (?), which aroused considerable interest. Microscopical sections will be shown at the next meeting, and the full notes of the case will then be published.

Mr. G. W. DAWSON showed for Dr. KNUTSHEN a man, aged 30 years, on whom a rash appeared on the arms and legs several weeks ago. The

* In regard to the possibility of the case being a localised and incomplete form of Recklinghausen's disease, it must be remembered that the distribution of neurofibromatosis may be to a certain extent unilateral, one half of the tongue or one half of a lip being affected.

exhibitor considered the case one of *purpura*, the most prominent lesion being hæmorrhage into the cutis. There were, however, certain parts of the eruption presenting indefinite papules, which to some present suggested Lichen planus of a hæmorrhagic type. There was no itching or other subjective symptoms whatever.

Dr. GRAHAM LITTLE showed (1) a private case for diagnosis (query early leprosy). The patient was a Rhodesian farmer, who had lived continuously in Africa for sixteen years, the last twelve of which he had spent in Rhodesia. His home was on the north-west border, about one hundred miles from the Victoria Falls. He had, on the whole, enjoyed splendid health and was now a very fine specimen of young manhood, in spite of attacks of blackwater fever. He was aged 29 years, originally a native of Russia, and of Hebrew race. Fifteen months ago, while still in Rhodesia, he noticed an eruption on the glans penis, consisting apparently of small papules which had persisted continuously up to the present time. He came to Europe six months ago, and in Vienna consulted Prof. Müller of the Venereal Hospital, as he had been told by some other doctors that he had syphilis. A careful examination was made in Vienna by Wassermann's original test as well as by modifications of it, and the result was recorded as negative, Prof. Müller informing him that it was not advisable to undertake a course of syphilitic treatment. About this time, *i. e.* some three months after arriving in Europe, he noticed in addition to the eruption on the penis, which persisted unchanged, some faint ringed patches on his chest. He complained at the same time of a sore throat and a cold in the nose with some epistaxis. He was sent to the exhibitor on January 2nd, 1911, by Dr. Garlick, of Gordon Square. He had at this time a number of faintly pink-edged, large circinate patches on the chest and abdomen, the areas varying in diameter from one to four inches, the edges raised, congested, not scaly, the redness being easily obliterated by pressure. There was no itching complained of in these patches, and except for seeing them he was unaware of their existence. Factitious urticaria was very well marked. On the penis there was a serpiginous-outlined papulo-squamous eruption running round three quarters of the glans. The glands in the neck were definitely enlarged, and the patient felt run-down, easily tired, and depressed. The exhibitor at this visit thought

the diagnosis of syphilis most probable, in spite of the negative result of the Wassermann test; he regarded the circinate rash as a possible "roseole tardive" of French authors; indeed, it strongly recalled the plate in Jacobi's *Atlas* with that label. A Wassermann test was again made by Dr. Fleming, using his own modification of that test, and the result was reported to be negative. The view was then taken that the eruption might be a circinate erythema as described by Colcott Fox. There was no nasal catarrh at this time, and his voice was unaltered. His temperature on January 2nd, taken during the consultation, was 99° F., his pulse 100, and his blood-pressure, measured by Leonard Hill's instrument, 80. He was given a mixture of calc. phosph. and calc. lact., gr. xv of each, three times a day after meals, and a salicylic acid ointment to apply to the penis. He was seen again on February 16th; the circinate lesions had, if anything, become more vivid in colour, but were still quite pale pink, with very little-raised margins; the penile lesion had greatly diminished, and his general health and feelings were much improved. The possibility of leprosy was now entertained by the exhibitor, and the patient was closely questioned as to the liability of contagion. He said the disease was constant amongst the natives in his locality, but not amongst the whites; that he had never come into contact with patients suffering from it. He was quite out of the zone of sleeping-sickness (which is attended by a transient eruption not unlike that now present in the patient). He had again contracted a severe cold, and was suffering from nasal and laryngeal catarrh. Careful testing of the tactile and thermal sensation in the areas of the eruption showed no paræsthesiæ or anæsthesiæ. The ulnar nerves above the elbow on both sides, but perhaps more markedly on the left, were, it seemed to the exhibitor, definitely thickened; they could be handled somewhat energetically without producing any pain. There were no lesions in the mouth.

The patient was returning to Rhodesia on February 18th, and he was engaged to be married in the near future. He had never had syphilis to his knowledge, and had not any appearance of scarring from a chancre or history of secondary eruption. He lived a healthy out-door life on a cattle ranch in a country with a magnificent climate, and had not been nearly as well in Europe as in Africa.

The provisional diagnosis of leprosy was hazarded by the exhibitor in spite of the absence of anæsthesia. An extremely interesting case,

in which a diagnosis of syphilis had been maintained for five years by numerous eminent specialists, and which eventually was demonstrated to be leprosy, was recorded by Audry (*Ann. de Derm. et de Syph.*, May, 1910, p. 274). Here also there was no anaesthesia. Other cases were on record in which anaesthesia was delayed in cases ultimately demonstrated to be leprosy.

Subsequent to the meeting this man had been examined by Sir A. Wright, who found no evidence of leprosy in the discharge from the nasal cavity. The patient had refused a biopsy, and no other investigations could be carried out.

Sir MALCOLM MORRIS regarded the case as sufficiently suspicious to justify the idea that it was commencing leprosy. If the case could be seen somewhat later and a biopsy made it would perhaps settle the diagnosis. It was not yet far enough advanced to do that. The case looked very much like one which he saw at St. Mary's Hospital. In that also there was absence of anaesthesia at that stage, but it came later. Even at that early stage there was some enlargement of the ulnar nerve, as in this patient. In the Bergen Leprosy Congress great stress was laid on the early involvement of the nasal mucous membrane.

Mr. DAWSON agreed that it was probably an early case of leprosy, a disease which was common in the Transvaal.

Dr. STOWERS agreed that the case was suspiciously like early leprosy, but suggested that the possibility of *Mycosis fungoides* should be borne in mind.

The PRESIDENT remarked that if the case was syphilitic it would be an example of one of the late circinate eruptions, such as Unna had described. The nasal catarrh was noticeable, and one should remember how often leprosy began in the nose. With regard to marriage, he had known lepers in this country who had lived with their wives for years without the latter getting the disease.

Dr. PERNET considered a case of this kind required careful investigation, but it was suspiciously like leprosy. He had seen somewhat similar cases which turned out to be certainly leprosy. In a case of so-called neuro-lepride he had found *lepra bacilli*.* Alterations of sensation were not necessarily present in early cases. The serum of a lesion should be examined, and a biopsy should be done. An important feature was that the condition began on the penis. Glück,† of Serafero, had spoken specially on the subject. The case also raised the question as to the segregation of lepers.

Dr. MACLEOD said that he agreed that there was a difference in the thickness of the right and left ulnar nerve, the right one being distinctly thicker, and considered that the eruption was suspiciously like *lepra*, but that in the absence of sensory disturbances within the ringed lesions it was difficult to come to a

* *Brit. Journ. Derm.*, vol. xii, 1900, p. 450. Pernet had suggested the case he examined was really a flat infiltration (*en nappe*). Darier had found bacilli in neuro-leprides (cited Jeanselme, *Dermatologie Exotique*, p. 24).

† Glück, "Zur Kenntniss der leprösen Affektionen an der Glans Penis," *Lepra*, vol. i, 1900, p. 4.

definite decision with regard to the diagnosis. He did not think that much assistance would be derived from a biopsy, as it was doubtful if lepra bacilli occurred in such lesions, and the histo-pathology was not characteristic. He suggested a further examination of the nasal mucosa for the bacilli, particularly after some iodide of potassium had been given to increase the discharge.

Dr. WILFRID WARDE said that while he was at Dr. Unna's clinique he saw exactly similar cases. Unna said they were cases of leprosy of the nerves, and that often no bacilli could be recovered from the patch. He, Dr. Warde, did not think that generalisation was strictly true. He had seen a case from Brazil, in which there was a round patch and a very thick nerve. It was so important that a diagnosis should be made that a piece of the ulnar nerve was excised, and then a small worm was found; he saw it mounted, and it was a very beautiful specimen. No zoologist in Hamburg knew what it was. The enlargement was bilateral. Possibly a piece of the present patient's nerve might be excised.

Dr. GRAHAM LITTLE, in reply, thanked members for their opinions. Further investigations were, however, out of the question, as the patient would be returning home in three days.

(2) A case of *Nævus pigmentosus, verrucosus et pilosus*. The patient was a boy, aged 2 years, and the condition was congenital. He presented a most remarkable appearance, as will be evident from the following description. The whole of the trunk (with the exception of a small area under the left axilla) was occupied by a pigmented nævus, which stretched behind from the nape of the neck to the middle of the sacrum, and in front from the neck to the pubic region. On the upper part of the back there were large warty areas superposed on the pigmented skin, and the whole of the back and sides of the trunk were covered with long hair; the pigmented portion on the abdomen was not hairy or warty; only a small portion of the skin over the left side of the chest and under the left axilla was not affected. The right shoulder and the right upper arm were also covered entirely with a hairy, warty, and pigmented nævus, continuous with the pigmented areas of the back; below the elbow the skin was normal, but with numerous small, discrete, rounded nævi; on the back of the wrist there was another hairy, slightly raised, pigmented area the size of a florin. The backs and fronts of the hands were normal. The face was thickly peppered with small, discrete, warty, and flat nævi; on the forehead there was a large hairy nævus contiguous and shading into the scalp, which was elsewhere unaffected. Small, rounded, warty and pigmented nævi were thickly scattered over the thighs and legs down to, and including, the dorsum of the feet; the soles were unaffected. There was a

large, raised, hairy, pigmented patch, about two by one and a half inches in diameter, on the front of the right leg just above the ankle. The left ankle was tuberculous. There were six other children, who showed no similar lesions. There was no family history of congenital malformations.

(3) Two cases of *Nævus unius lateris*, which served as remarkable companion pictures, the lesions being on similar portions of the body but on different sides. The first case was in a girl, Ethel O—, aged 12 years. The condition had been present from birth. There was a linear streak starting from just in front of the lower lobe of the right ear, and pursuing a somewhat zig-zag course, roughly corresponding to the anterior border of the sterno-mastoid muscle, and terminating about an inch above its insertion into the sternum. The line was irregular in thickness; starting narrow, it bulged into an oblong or fusiform broader area in the middle of its course, and again became thinner at its termination. The line was made up of salient, warty, pigmented, discrete nævi, except in the broader middle area, where a uniform elevated pigmented mass was present. This portion had been treated with freezing by carbon dioxide snow, with good result, for the pigmented warty mass had been dislodged, leaving very little cicatrix. It was, however, a very tedious procedure; exposures had averaged from 30–60 seconds, and had been repeated about ten or twelve times. With the exception of a very small isolated, warty, pigmented growth on the lower lobe of the right ear the distribution was confined to the neck. There was no other member of the family similarly affected.

The second case was in a boy, Reggie W—, aged 11 years, a small child for his age. He had a congenital linear nævus extending downwards from behind the lower lobe of the left ear, along the anterior border of the sterno-mastoid to a point about an inch above the clavicle; along this course the streak was made up of warty pigmented nævi, with varying degrees of breadth. In the supra-clavicular fossa there was a non-pigmented, flat, warty patch with a few discrete, flat, non-pigmented wart-like nævi running down on the chest in a line about an inch below the clavicle. On the left cheek there was a large patch of non-pigmented flat warty growth about $1\frac{1}{2}$ by $2\frac{1}{2}$ in., the longer dimension being vertical, and the whole

patch separated by about $1\frac{1}{2}$ in. from the external ear. There were several isolated warty naevi, some of them pigmented, on the pinna, in the concha, and around the meatus of the left ear.

There was a small isolated patch of congenital alopecia, about three-quarters of an inch in diameter, on the scalp in the vertical line of the left ear and about two inches above the pinna. The distribution of the portion of the naevus confined to the neck in both these cases offers a great resemblance to part of the area described by Head as the sterno-mastoid area in the following terms ("Disturbances of Sensation and the Pain of Visceral Disease," *Brain*, 1894, p. 368): "The descending portion of the (sterno-mastoid) area lies over the sterno-mastoid and almost exactly follows the anterior border of this muscle. On the front of the chest it reaches the upper border of the second rib." In the further description of this area on p. 378 of the same paper the author says, "It is noteworthy that the area always sends a small anterior portion to a point on the cheek just below the ear." This *may* correspond perhaps to the patch of naevoid tissue seen on the cheek in the second case noted above, although this patch was certainly higher on the cheek than would coincide with the description of the herpetic eruption which served to indicate this area in Head's narrative (see fig. 22, p. 378, *loc. cit.*). The alopecic patch on the scalp, noted in the second case, was unique in the exhibitor's experience in connection with this grouping of linear naevi.

Dr. STOWERS referred to a very much more marked case of the same kind which he showed in 1907, and published in detail under the title of "Congenital Ichthyosis Hystrix Linearis, syn. Naevus Verrucosus," in the *British Journal of Dermatology*, vol. xx (1908), with illustrations. The extent and symmetry of the disease were very remarkable. Several of the growths were so considerable, projecting from the surface to an extent exceeding half an inch, that excision was necessary.

Dr. PRINGLE suggested that the best way of treating so narrow a linear naevus was by excision. The result was rapid, and there need be little or no scarring. In such cases as that of pigmented naevi, there were often patches of hair not only bilateral but remarkably symmetrical.

Dr. J. M. H. MACLEOD showed a case of *small-spored ringworm of the scalp in a woman, aged 23 years*, who had been affected from her son, a boy of six, who suffered from the disease. The patient was a strong-looking young woman, with thick, rather coarse black hair.

Her scalp appeared to be otherwise healthy, was not scurvy, and she had never had ringworm before. On the left frontal area, about an inch behind the anterior border of the scalp, there was a small, partially bald patch about the size of a shilling. Over this were a few irregular stumps, which, on being examined under the microscope, presented the typical appearances of microsporon ringworm. She had first noticed the lesion about two months ago.

The PRESIDENT remarked that he had only seen a few similar cases, and that, considering the prevalence of microsporon ringworm, it was certainly rare to see an adult affected.

Dr. PRINGLE said he remembered having seen only three cases of small-spored ringworm in the scalp in adults. One was a lady, aged 45 years, and in her the disease began as a circinate eruption on the forehead, spreading into the scalp. The second was a young nursery-maid who contracted it from children under her care; and the third was a very old woman, about 80 years of age, who was almost completely bald, also attending to children with ordinary London ringworm.

Dr. SEQUEIRA showed a case of *non-ulcerating tuberculide*, *Boeck's miliary sarcoid* (?), following *Lupus vulgaris*. The patient had been previously shown at the meeting of the Section on January 20th, 1910 (*Trans. Dermat. Sect. Roy. Soc. Med.*, 1910). The patient was aged 21 years. He had suffered from *Lupus vulgaris* since he was nine years of age. The skin of the nose and both cheeks had been extensively affected, and he had been submitted to four scraping operations before he came under Dr. Sequeira's care. The lupus was of a warty type, and after a preliminary curetting the areas were submitted to the Finsen light with good results. Occasionally the patient came up from Suffolk, where he resided, and in May, 1909, he was found to have a number of small shotty swellings behind both ears and on the adjacent parts of the neck and forehead. The nodules have persisted, and there were still about forty of them present when the patient was again shown. The condition had not changed in the least, and none of the nodules had ulcerated. A few on the forehead had disappeared, leaving small depressed cicatrices. Each nodule was hemispherical in shape, of a purplish-brown colour, and about 2 mm. in diameter. They felt exactly like shot embedded in the cutis.

Dr. Sequeira quoted the report which Dr. Turnbull had made of the structure of an excised nodule. It was found to be limited to the dermis at the base of a hair-follicle. Its stroma consisted of a reti-

culum of fine fibrils, with spindle and elongated nuclei. In the central parts the nuclei were very abundant. The reticulum contained capillaries, and was densely infiltrated with free cells, most of them being lymphocytes, but there were also eosinophile polymorpho-nuclear leucocytes. There was some extra-cellular pigment. In the upper part of the nodule there was a rounded space containing concentric lamellæ of horny substance, bounded by one or two layers of flattened epithelium. No giant-cells were found, and no tubercle bacilli.

The symmetrical arrangement of the nodules and the absence of peripheral extension excluded *Lupus vulgaris*, and the exhibitor, therefore, concluded that the eruption was a tuberculide. However, the fact that there had been no ulceration during twenty months showed that the eruption was not one of the common forms of tuberculide, but resembled the condition described by Boeck as "miliary sarcoid."

The exhibitor regretted that it had been impossible to carry out the suggestion made by Dr. Pringle in January, 1910, viz. to excise a nodule and inoculate a guinea-pig with the material. The patient gave the von Pirquet reaction, but this was of no assistance, as he was already suffering from *Lupus vulgaris*.

The PRESIDENT said that very few cases of tuberculides produced tuberculosis when inoculated. It had not the distribution of *Acne varioliformis*.

Dr. GRAHAM LITTLE asked why this was not an example of sarcoids, if that term were to be accepted. He did not think the clinical aspect was that of any described form of tuberculide.

SIR MALCOLM MORRIS remarked that it would have been interesting to learn what the diagnosis would have been if there had been no lupus in the case and only the nodules had been seen. In those circumstances he did not think that a tuberculide would have been suspected.

CURRENT LITERATURE.

FUNGUS INFECTIONS OF THE FINGER-NAILS. R. CRANSTON
Low. (*Edinburgh Med. Journ.*, February, 1911.)

THIS is a very valuable contribution to the subject, and those interested should read the whole paper. Dr. Low saw 19 cases of fungus disease in three years. Of these 16 were trichophyton, 2 favus, and 1 an unknown fungus.

Of the ringworm cases 14 were in females and 2 in males; the youngest patient was 11 years of age and the eldest 58, most being between the ages of 20 and 30 years.

As regards the source of infection this was doubtful in most cases, but in one instance husband and wife were both infected, and in another two sisters suffered from the disease. In one case the patient was the mother of children suffering from scalp ringworm due to the same fungus.

The duration of the cases was from three weeks to seven years. In no case did Dr. Low meet with ringworm of the toe-nails.

In his description of the microscopic appearances of the infected nails he describes branching fungus and chains of square spores, but surely these square bodies are the typical short mycelial elements of the *T. megalosporon*.

Cultures were obtained from 8 cases, in 5 cases showing *T. crateriforme flavum*, in 2 *T. rosaceum*, and in 1 an unknown fungus of woolly aspect. Excellent photographs are given showing the appearances of the fungi. As regards treatment, Dr. Low finds Harrison's method successful, and also gives a new method suggested by Norman Walker. This consists in soaking the nails under lint and finger-stall with ordinary Fehling's solution for a day or two, removing the softened nail, which he says can be easily done, and then dressing continuously with copper sulphate in a strength of 10 gr. to the ounce of water.

As regards other investigations on this subject, to which Dr. Low refers, there are a few more scattered observations in the literature than he gives. Pernet showed a culture of endothrix at the Dermatological Society of London (*Brit. Journ. of Derm.*, vol. xiii, 1901, p. 476), Sequeira published an endothrix case (*Brit. Journ. of Derm.*, vol. xviii, August, 1906), and I showed an ectothrix at the same Society (*Brit. Journ. of Derm.*, vol. xvi, 1904, p. 465). There is no doubt that the endothrix is the common form of fungus present, though I believe Dr. Low is the first to cultivate *T. rosaceum* from the nail. My own series now consists of four successful cultures, three of which were *T. crateriforme*, and one, already alluded to, an ectothrix. This latter I believe to be unique at present.

A. W.

ÉTUDE SUR LES RÉACTIONS DES SYPHILITIKES À LA TUBERCULINE. ANDRÉ AUGAGNEUR. (*Thèse de Lyon*, 1910, pp. 103.)

THE author formulates the following conclusions:

(1) As far as dermic and intra-dermic reactions to tuberculin are concerned, syphilitics, clinically non-tuberculous, react in as great a number as tuberculous subjects (80 per cent.).

(2) The former also react (febrile and general symptoms) in the same proportion to the subcutaneous injection of tuberculin.

(3) In syphilitics the reaction is as well marked as in the tuberculous.

(4) Syphilitics are apparently less sensitive to the ocular reaction (45 per cent.).

(5) The specificity of the cutaneous and subcutaneous reactions to tuberculin cannot be admitted. Neither the intra-dermic, the dermic, nor the subcutaneous reactions to tuberculin serve to distinguish tuberculosis from syphilis.

Dr. Augagneur confirms the conclusion arrived at by Nicolas, Favre and Charlet (of Lyons), who had found that tuberculin employed on the lines laid

down by von Pirquet and by Charles Mantoux did not serve to differentiate syphilis from tuberculosis.

It should be mentioned in passing that as far as the ocular reaction is concerned, the author includes two cases of Lupus erythematosus among the tuberculous cases (*tuberculosés cutanées*); one gave a positive result, the other a doubtful one. There is a bibliography.

GEORGE PERNET.

ULCUS NEUROTICUM MUCOSÆ ORIS (CHRONISCHE APHTHEN).

LÖBLOWITZ. (*Archiv f. Derm. u. Syph.*, vol. cii, 1910, p. 191.)

THESE ulcers occur in the mouth after puberty and disappear when the patient is about thirty. The ulcers often get well for a time, to break out later. There is often a strong family history, and the patient is usually suffering from some nervous affection, most frequently in the form of neurasthenia. The commencement is a small papule under the mucous membrane, lips, and cheeks, and is painless; it increases in size, usually with a slight rise of temperature, the height depending upon the number of lesions present, and in two or three days an ulcer has formed. The ulcer is irregular, sharply circumscribed, ranging from the size of a lentil to that of a bean, is covered with a greyish-white deposit, which cannot be removed, and has a marked infiltration around with a broad inflammatory zone. If the ulcer is in a region where it is constantly irritated, as behind the last molar, it may reach a considerable size and become crateriform. The base becomes secondarily infected with micro-organisms, Plant-Vincent bacilli, etc. Corresponding lymphatic glands are swollen and painful, salivation is increased; there is often œdema of the mucous membrane, and the pain caused by eating and drinking is intense. After a week the gangrenous bases of the ulcers come away and the surface quickly becomes covered with healthy granulation-tissue, and in three weeks, even in bad cases, the scar is complete. This form of ulcer is distinguished from the follicular or dyspeptic ulcer, in that the ulceration of the latter is superficial, has a thin white base, and a broad, *not* infiltrated, inflammatory zone. It is often hard to differentiate a neurotic ulcer from the syphilitic, but in the latter pain is usually absent and there is no inflammatory zone around the ulcer, and further, the aphthous ulcer is not alleviated by painting with silver nitrate or chromic acid. The differential diagnosis from Herpes buccalis is easy when one bears in mind that the latter commence in little groups of vesicles upon a raised mucous membrane which is soft and œdematous; even when the central lesions have coalesced and become covered with a pseudo-membrane there is always a collarette of vesicles. The ætiology is probably of angioneurotic origin, analogous to Herpes zoster, Herpes febrilis, etc., due to irritation of the vaso-dilator centre by psychic stimuli. Kreibich regards the irritation of the vaso-dilator centre to be either functional (hysteria), or due to organic disease of the central nervous system (syringomyelia, tabes, etc.) or to auto-intoxication (ovaries).

J. McD.

ON THE SO-CALLED BOTRYOMYCOSIS OF MAN. LENORMANT.

(*Ann. de Derm. et de Syph.*, April, 1910, p. 161.)

THIS is a full review and *resumé* of the various theories that have been put forward to explain a type of disease which is clinically very well distinguished,

but pathologically remains unexplained. The identity of the equine botryomycosis with the so-called human variety is no longer claimed, and the parasitic nature of either is more than doubtful. All that can be said with any wide assent is that the tumour is inflammatory, that it is not due to any special organism that has been identified; that possibly infection and injury play a part in its production. As the term "botryomycosis" connotes a pathological theory no longer tenable, the author proposes its abandonment in favour of the term "pedunculated granuloma" (*Granulome pédiculé*). The tumour is invariably benign, and excision of the growth with its base of skin (not merely its pedicle) is the best treatment to adopt; recurrences are extremely rare after this procedure.

E. G. L.

THE DEMODEX FOLLICULORUM OF MAN IN THE HEALTHY SKIN. DU BOIS. (*Ann. de Derm. et de Syph.*, April, 1910, p. 188.)

Du Bois tested 200 persons varying in age from twenty to eighty-five years; in every one of these the demodex or its larvæ proved to be present. The nasal appendage is the most convenient place to find the parasite. In another series of cases of persons under twenty the examination was negative in children under five years; between five and ten years half the number examined showed the parasite; after ten years the percentage of success was the same as after twenty. The parasite produces eggs which develop into the hexapod larval forms.

E. G. L.

ON A VEGETATING LYMPHODERMATITIS DUE TO SACCHAROMYCES (S. GRANULATUS OF VUILLEMIN AND LEGRAIN). PELLIER. (*Ann. de Derm. et de Syph.*, April, 1910, p. 191.)

THE patient was a man, aged 27 years, the subject of syphilis. A year after contracting this disease he began to show symptoms ultimately referable to the invasion of the tissues by a saccharomyces, which Prof. Vuillemin identified with his "*Saccharomyces granulatus*." This organism was not found in the tissues of the skin removed by a biopsy, but it was seen in the lymph obtained by puncture, and was grown from this with ease on glucose agar. Inoculation into the eye of a rabbit and hypodermic injection gave negative results.

E. G. L.

ON A CASE OF GRANULOMA DUE TO FAVUS. DARIER and HALLÉ (*Ann. de Derm. et de Syph.*, March, 1910, p. 129.)

THE explanation of the cicatricial atrophy which follows favus has not been either consistent or satisfactory. Malassez showed that it was possible for the parasite of favus to penetrate into the corium, and Renaut, in 1876, wrote an explanation founded on these observations of Malassez, by which the scarring of favus was ascribed to this penetration of the corium and subsequent absorption of connective tissue. Darier and Hallé were able to demonstrate in a case of favus the existence of a granulomatous nodule in the corium, but were unable to find Favus mycelium in this infiltrated nodule. They do not, however, claim that these granulomatous infiltrations explain the scarring of favus, which remains to be solved.

E. G. L.

ON A NODOSE AND SYMMETRICAL DISEASE OF THE FACE.AUDRY. (*Ann. de Derm. et de Syph.*, March, 1910, p. 137.)

THE patient was a woman, aged 30 years, in whom the first symptom had been the presence of a deep-seated nodule on one cheek. This had become converted into a wider infiltration of the tissues of the cheek, and a similar sequence of events, with a similar termination, was noticed on the other cheek. Histological examination did not furnish any definite diagnosis, but Audry came to the conclusion that this was an instance of hypodermic sarcoid, notwithstanding the absence of the "tubercular follicle," on which Darier insists as a criterion of diagnosis of that condition. Inoculation of tissue into a guinea-pig was followed by no tuberculous development. The patient showed some improvement under treatment with calomel injections and iodide by the mouth. Syphilis, actinomycosis, and leukæmic infiltration could be definitely excluded by the histological features.

E. G. L.

A STORY OF A LEPER. AUDRY. (*Ann. de Derm. et de Syph.*, May, 1910, p. 274.)

THE patient was a man, aged 33 years, who had spent two years in Indo-China. Seven years after his return to France he began to suffer from headaches, vertigo, and anæmia, and was diagnosed at a hospital clinique as a syphilitic. For five years he was treated intermittently for syphilis, this diagnosis being confirmed from time to time at five different cliniques. The symptoms had in no way bettered; gross ulceration had taken place in the palate and the perinæum, with facial paralysis. Audry at first confirmed the previous diagnosis of syphilis, but after a month's treatment for this disease, in face of complete failure, revised the diagnosis, demonstrated thickening of the ulnar nerves, and the presence of acid-fast bacilli in the nasal mucous membrane, and established the presence of nerve-leprosy. It was noteworthy that there had been no anæsthesia.

E. G. L.

ON A CUTANEOUS TRICHOPHYTIA WITH LARGE CIRCLES. CAUSED BY A NEW DERMATOPHYTE. BANG. (*Ann. de Derm. et de Syph.*, May, 1910, p. 225.)

TWO cases were observed, both in subjects who had recently visited America, of an eruption, appearing in circles from 4-10 cm. in diameter, consisting of a papular edge, and a darkish, rather scaly centre, and situated chiefly about the scrotum, sacrum, and thighs. In the second case the wrists and forearms were also affected. Both cases were cured within three months by ointments containing salicylic acid or sulphur iodine or chrysarobin. Scales showed a typical mycelium, and a purple culture was grown on maltose agar. No infection of the hair by the parasite could be observed or determined by experimental inoculation. The author regards it as a large-spored ectothrix, constituting the fourth species that has been isolated which grows a purple culture, and names it "Trichophyton purpureum Bang, 1910."

The paper contains several illustrations of the clinical and microscopical aspect.

E. G. L.

SOME CONSIDERATIONS ON THE ACTION OF SULPHUR IN DERMATOLOGY. BRISSON. (*Ann. de Derm. et de Syph.*, June, 1910, p. 297.)

THIS is a study by a pharmacist of the action of sulphur (1) in an oily medium at a temperature of 40° in the presence of chloride of sodium and various catalytic agents; (2) in a watery, oily medium, in the presence of chloride and organic matter under the influence of X-rays at a temperature of 15°; (3) of the dosage of sulphur in various Galenical and opotherapeutic preparations; (4) the rôle of sulphur in various manifestations of life. The conclusions drawn are that sulphur in the presence of chloride of sodium and serum is transformed into sulphuric acid with a rapidity which varies with the temperature and the presence of catalytic agents. Sulphur dissolves readily in the presence of greases with a facility which varies with the temperature, the presence of chloride of sodium, of arsenic, and other catalytic agents. The presence of electricity acts like temperature in accelerating the effect of sulphur and the formation of sulphuric acid.

E. G. L.

ON THE FREQUENT EXISTENCE OF A SO-CALLED ECZEMA OF THE FINGERS AND TOES DUE TO THE EPIDERMOPHYTON INGUINALE. SABOURAUD. (*Ann. de Derm. et de Syph.*, June, 1910, p. 289.)

ECZEMA marginatum or tinea cruris has been usually ascribed to the invasion of the skin by a trichophyton. Sabouraud, in this paper, demonstrates that the organism is *sui generis*, in the same way that Pityriasis versicolor and erythrasma are the product of fungi in no way related to the trichophyta. The eruption on the thigh is very frequently associated with an eruption on the fingers and toes, which may closely simulate an eczema, but in which the fungus may be found. The parasite is very hardy, and the treatment most successful in curing the disease is by the anointment of the part affected with chrysarobin in 1-3 per cent. ointment with or without the addition of salicylic acid.

E. G. L.

NOTE ON THE BACTERIOLOGY OF PYODERMATITIS. DUBREUILH and BRANDEIS. (*Ann. de Derm. et de Syph.*, June, 1910, p. 323.)

PYODERMATITIS is used to cover all affections of the skin due to local infection by the ordinary organisms of suppuration. Certain clinical varieties are the subject of investigation by these authors, of which furunculosis, ecthyma, impetigo in its various forms, contagious impetigo of Tilbury Fox, bullous impetigo, impetigo of Bockhart, are the chief; they are unable to confirm the generalisation made by Sabouraud, by which all the types beginning with a vesicle or bulla are due to streptococcic, those beginning with a pustule to staphylococcic, infection; in eight cases of Impetigo contagiosa clinically typical they found staphylococcus and streptococcus equally often; in one case of Impetigo circinata they found streptococcus only; in three cases of bullous impetigo they found staphylococcus in two, streptococcus in one. In two cases of Bockhart's impetigo both gave pure staphylococcus, but in one case there were also some streptococci; in ecthyma (one case) staphylococcus was found. The clinical aspect of the lesions does not,

in these authors' opinion, furnish any certain indication of their bacteriological content.

E. G. L.

TREATMENT OF PUSTULAR ACNE BY VACCINES. LASSUEUR.
(*Ann. de Derm. et de Syph.*, July, 1910, p. 377.)

LASSUEUR, experimenting with vaccines derived from the laboratories at St. Mary's Hospital in cases of acne, either simple, or complicated by suppuration, and with the addition of no local treatment, found in nine cases of pustular acne with comedones manifest improvement in the pustulation after the use of mixed vaccines of microbacillus of acne plus staphylococci. In eight cases the effect was almost *nil*; in three cases there was temporary aggravation of the pustulation, probably, as the author says, due to too close approximation of dosage; in two cases of pure comedo-formation there was pronounced improvement. The injection consisted of 5-10 million acne bacillus vaccine every five to ten days, and 125-250 million staphylococcus vaccine every five, ten, or fifteen days.

E. G. L.

A CONTRIBUTION TO THE STUDY OF THE MORPHOLOGY AND DEVELOPMENT OF SPOROTRICHUM BEURMANNI. RISPAL and DALOUS. (*Ann. de Derm. et de Syph.*, July, 1910, p. 372.)

By means of a special technique devised and described in detail by these authors, they have been able to study the formation of this organism from the initial spore to the accomplished terminal segmented mycelium. The stages of growth are depicted in figures, illustrating the appearances after 22, 38, 42, 56, 65, and 72 hours, and finally after five days, when the mycelium is fully formed and segmented in parts. Sporulation commences usually by the end of the third day. The spore develops best in an aerated liquid medium, and it is suggested that this fact should be utilised in diagnosis, a drop of suspected pus being placed in maltose-bouillon kept in a well-aerated vessel for two days, and the contents then examined, by centrifugalisation if necessary, for fragments of mycelium.

E. G. L.

OPOTHERAPEUTIC TREATMENT OF SCLERODERMIA. ROQUES.
(*Ann. de Derm. et de Syph.*, July, 1910, p. 383.)

THE arguments for the connection of thyroid inefficiency with scleroderma are based on the frequent disorders of the thyroid associated with that disease, disorders such as hypertrophy, atrophy, sclerosis, and diminution of iodine-content. In thirty-one cases of diffuse scleroderma where the state of the thyroid was mentioned there were clinical modifications in that body in twenty-two instances. Moreover, Basedow's disease has been often observed in company with scleroderma. The resemblance of myxœdema and scleroderma has been frequently commented on. In a carefully tabulated record of the effects of thyroid administration success was noted in 63·7 per cent. The treatment should be begun early, and should consist of small doses continued over a long period. Supra-renal extract has been used with benefit in some cases. Pituitary extract failed to exert any effect in four cases in which it was tried. Testicular and ovarian

extracts have also been used, mostly without success. Schwerdt, in five cases of localised sclerodermia, had promising results with mesenteric gland preparations.

A very full bibliography is appended.

E. G. L.

NOTES ON THE STRUCTURE OF THE NAILS. BRANCA. (*Ann. de Derm. et de Syph.*, July, 1910, p. 353.)

THIS is a closely reasoned histological description of the formation of the nail in the monkey (*Macacus sinicus*) and in the human being. The author examines the different views which ascribe the growth of the nail entirely to the cells of the matrix so-called, or to those of the whole bed of the nail, including the matrix, and favours the latter view. He also combats the theory proposed by Bowen, by which the horny border (*limbe corné*) of the nail is regarded as the homologue of the stratum lucidum. He would regard it as a structure *sui generis*, like the hair, and the homologue of the several layers of the epidermis.

E. G. L.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

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